# LA FORCE HEMOSTAT TONSILLECTOME.*

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At a meeting of the Academy of Ophthalomology and Oto-Laryngology I made a preliminary report of an instrument devised for the bloodless enucleation of the faucial tonsil back of its capsule.

Before the instrument was presented and the preliminary report made, Dr. Joseph Beck of Chicago, who has helped very materially to work out the technic of the operation, and I applied the hemostat and ligature to the faucial tonsil back of the capsule and a complete enucleation was done without the loss of a single drop of blood.

The operation of applying the hemostat back of the capsule, crushing the tissues for seven minutes, and enucleating the tonsil in the adult as well as in children was done with the loss of only enough blood to tinge the mucus.

From my experience with the instrument before the report was made and since that time, and from my observation of the instrument in the hands of several noted laryngologists, including the very skillful preliminary work done by Dr. Beck, I feel justified in making the statement that I am convinced this instrument will be of decided usefulness.

The instrument is provided with a hemostat which has two crushing-surfaces something similar to the blades of an artery forceps, which are about two and one-half mm. broad, a ligature carrier, a cutting-blade and an opening made almost square, in which the tonsil is engaged.

The tonsil is engaged into the fenestra of the instrument after the method of Dr. Sluder, the crushing-blade forced down back of the tonsil and all of the tissues immediately in apposition to the tonsil held firmly between the two crushing surfaces by screwing down the wheel attached to the crusher. The hemostat is allowed to remain in place from five to ten minutes; the time should be determined accurately by the watch.

If the ligation is to be done, the ligature is placed in the groove over the end of the ligature-carrier with the ligature held firmly against the end of the carrier by engaging the ligature, after being tightly drawn, into a small spring catch. The ligature-carrier is then pushed forward through the pedicle produced by the hemostat, the ligature released from the spring catch and the ligature-carrier brought back leaving the loop on the farther side of the pedicle. The loop is then caught with forceps and brought around the handle-end of the instrument, one end of the ligature passed into the loop and the ligation of the pedicle completed by tying it either with or without a ligature knot tier made for this purpose..

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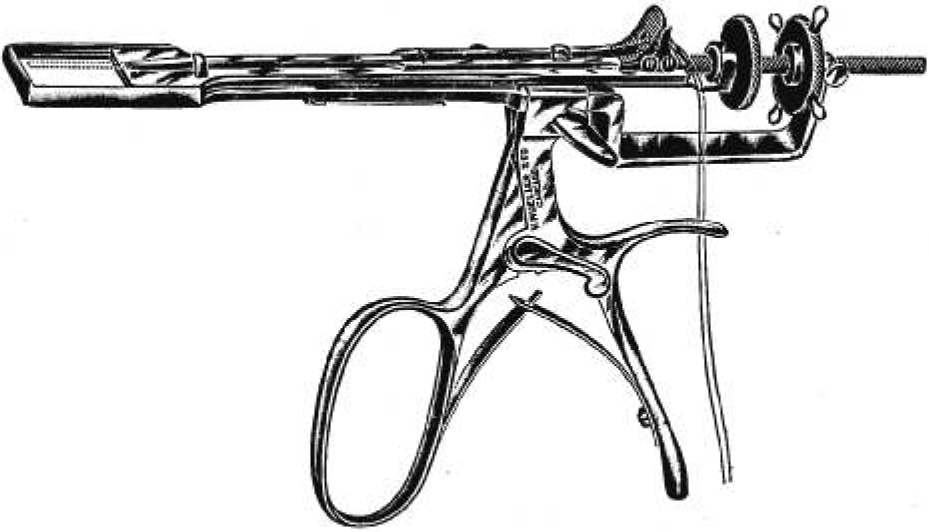
The ligation has also been accomplished by looping a number one snare wire over the ligature-carrier and running the loop of wire through the pedicle. If it is to be tied in three sections, the ligature carrier is displaced as far as it will go upward, and having penetrated the pedicle in this location, the carrier is withdrawn, leaving the wire loop in place where it is to be grasped with forceps, the loop threaded with a ligature thirty-six inches long and brought through the pedicle from behind forward by retracting the wires. The ligature is then cut in such a way that the upper third of the pedicle may be tied.



The part of the ligature which is left through the pedicle we will call ligature number two, which we will say has ends A and B. We next put the ligature carrier as far down as it will go, put wire-loop over it as before, pierce the pedicle and put the end of the ligature that was left after ligature number one was made, taking the end that was through the pedicle we have called B, and pass it into the loop of wire. Then retract the wire, cut the loop and tie the middle third of pedicle and then tie the lower third of pedicle by tying the other two ends.

At this time one end of ligature number one is tied to one of the ends of ligature number two, and the other end of ligature number two tied to one of the ends of ligature number three, so that there will be no gaping of the stump when the tonsil is cut off and hemostat released.

After the hemostat has been applied for from five to ten minutes or after the ligation has been accomplished, the smaller wheel is turned to the right and the tonsil cut off, being held with forceps and removed. The larger wheel is then turned to the right, the catch on the hemostat released so that the instrument may be removed from the throat.

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## Congenital Occlusions of the Esophagus and Lesser Bowel.

EDINGTON. *Glasgow Med. Jour.*, July, 1913.

Two specimens are described which illustrate a malformation of the tracheo-esophageal septum. In both of them the upper segment of the esophagus ended as a blind sac attached to the trachea below the level of the larynx. A free communication existed between the lower segment and the trachea close above the bifurcation of the latter, and the upper and lower segments were not united by connecting bands. Both fetuses presented other malformations, one of them, transposition of the thoracic and abdominal viscera, septal occlusion of the duodenum, and atresia ant; the other, various abnormalities of the recto-vesical region.

Reference to the literature of the subject shows that both specimens were examples of the prevailing type of esophageal malformation. Discussing the etiology the author regards it as probable that the malformation is due to an abnormal relationship of the tracheo-esophageal ridges (which separate trachea-esophagus) to the posterior wall of the esophagus, the ridges becoming fused with the latter over a greater or lesser area. GUTHRIE.